Once completed, please return this complaint to SalusCare,
ATTN: QM Dept., 3763 Evans Ave., Fort Myers, FL 33901

SalusCare

STATEMENT OF COMPLAINT

PLEASE PRINT

Person Making Complaint:_____ **Date:**_____

Patient Name (if different than above):_____

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other:_____

Address:_____
Street Address City, State Zip Code

Phone Numbers: (Home)_____ (Work)_____ (Cell)_____

Date and Time Problem Occurred:_____

Describe Your Experience:

What steps would you like taken to resolve your concerns?

1. _____

2. _____

3. _____

Would you like us to contact you to follow up? (Circle one) Yes No

Complainant Signature_____ (If Present)

Should you want to take your complaint to another agency, we have provided contact information for you:

FL Dept. of Children & Families Office of Civil Rights 1317 Winewood Blvd. Bldg 1, Rm. 110 Tallahassee, FL 32399 (850) 487-1901 TDD (850) 922-9220	U.S. Dept of Health & Human Services Office of Civil Rights Atlanta Federal Center, Ste. 3B70 61 Forsyth Street, SW Atlanta, GA 30303-7886 Voice Phone (404) 562-7886 TDD (404) 331-2867	Central Florida Behavioral Health Network, Inc. (CFBHN). 719 US Hwy 301 S. Tampa, FL 33619 (877) 355-2377

Blank copies of Complaint Forms are kept on file for use in each SalusCare program office and given to patients/families/others upon request. Completed forms require response to the individual within five (5) working days. If the complaint cannot be resolved by the Program Supervisor, it will be sent to the Customer Service Manager or the Executive Assistant for further review.